BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

W. ALLEN PALMER, M.D.

Holder of License No. 9404
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-04-0896A

CONSENT AGREEMENT FOR DECREE OF CENSURE

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and W. Allen Palmer, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that by entering into this Consent Agreement, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. Respondent acknowledges and understands that this Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Respondent acknowledges and agrees upon signing this Consent Agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. Respondent further understands that this Consent Agreement, once approved and signed, is a public record that may be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

7. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

W. ALLEN PALMER, M.D.

DATED: 4/16/05

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 9404 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0896 after receiving a complaint regarding Respondent's care and treatment of a 58 year-old male patient ("T.W.").

4. On August 24, 2002, while on a flight from Phoenix to Detroit, T.W. experienced shortness of breath and diaphoresis. The plane made an unscheduled landing in Oklahoma, where T.W. was admitted to the hospital ("Oklahoma Hospital").

5. The Oklahoma Hospital emergency department physician diagnosed T.W. with symptomatic bradycardia and admitted T.W. to rule out acute coronary syndrome. T.W. was evaluated by the Oklahoma Hospital cardiologist and discharged with diagnoses of symptomatic bradycardia, chest tightness and chest pain, and a near syncopal episode. T.W. was instructed to followup with his cardiologist at home.

6. On August 27, 2002 T.W. returned home and presented to Respondent, a family practice physician, for followup. Respondent requested and was provided with the discharge summary from Oklahoma Hospital.

7. From August 2002 to July 2003 T.W. continued to have episodes of tightness in his chest, sweats, arm/shoulder pain, increased cholesterol and increased high blood pressure. T.W. saw Respondent almost monthly. Respondent changed T.W.'s medications and advised him of lifestyle changes but never referred him to a cardiologist.

8. On July 7, 2003, T.W. had a heart attack and was admitted to the hospital where it was discovered that he had "coronary artery disease with 60% left main, 90% left

anterior descending coronary artery (LAD) and 100% distal occlusion of the right coronary artery, as well as 69% disease of the left circumflex...."

9. On July 11, 2003 T.W. underwent a triple bypass and was discharged from the hospital on July 18, 2003.

10. On July 21, 2003 T.W. was reported to be doing well at noon, but passed away between 1:30 and 2:00 p.m.

11. The standard of care required Respondent to consider the signs and symptoms in a differential diagnosis, risk factors, and chest tightness. The standard of care also required Respondent to consider a possible cardiac condition and order appropriate testing such as an electrocardiogram (EKG) or stress test.

12. The standard of care also required Respondent to refer T.W. to a cardiologist.

13. Respondent's deviated from the standard of care because he did not work up T.W. in a timely manner for a possible cardiac condition and because he did not refer T.W. to a cardiologist.

14. T.W. was harmed because the delay in diagnosis and missed opportunity for earlier intervention for his cardiac problems resulted in an acute myocardial infarction necessitating a bypass procedure. T.W. died 10 days after the procedure.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(ll) - ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) - ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure for failure to aggressively investigate the possibility of coronary artery disease.

2. This Order is the final disposition of case number MD-04-0896.

DATED AND EFFECTIVE this 11th day of May, 2005.

[SEAL]

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of MAY, 2005 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 13th day of MAY, 2005 to:

W. Allen Palmer, M.D.
Address of Record

_____
Quality Assurance